SUMMARY OF CONTRIBUTION INCREASE FOR 2015 BENEFITS

The Trustees have adopted a change to the pricing philosophy applied historically. The pricing philosophy adopted for the 2015 benefit year is to break-even before investment income. The following contribution increases effective 1 January 2015 and was approved as such by the Council for Medical Schemes:

- Option A: 6%
- Option B Plus: 6%

IMPORTANT INFORMATION

We encourage you to share the content of this brochure with your family, so that they too will know what to do in an emergency situation.

Please note for Emergencies after hours during the week, weekends and Public holidays, please go to the nearest Hospital Emergency Department for medical attention should you be admitted, the hospital authorisation number will be obtained on the first working day. Also note that the Medical Scheme does not cover medical expenses incurred outside the boarders of South Africa.
1. MEMBERSHIP CONTRIBUTIONS

OPTION A

Monthly Contributions per Income Band and Dependent Type (if no subsidy applies):

<table>
<thead>
<tr>
<th>Option A</th>
<th>R0 - R5,650</th>
<th>R5,651 - R9,400</th>
<th>R9,401 - R13,550</th>
<th>R13,551 - R17,350</th>
<th>R17,351 - and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>1,968</td>
<td>2,085</td>
<td>2,298</td>
<td>2,436</td>
<td>2,607</td>
</tr>
<tr>
<td>Per Adult Dependant</td>
<td>1,278</td>
<td>1,356</td>
<td>1,494</td>
<td>1,584</td>
<td>1,695</td>
</tr>
<tr>
<td>Per Child Dependant</td>
<td>333</td>
<td>354</td>
<td>390</td>
<td>414</td>
<td>441</td>
</tr>
</tbody>
</table>

Total Contributions per Family Size 2014 & 2015 (if no subsidy applies):

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Total Contributions 2014 &amp; 2015 (if no subsidy applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R0 - R5,650</td>
</tr>
<tr>
<td>Member</td>
<td>1968</td>
</tr>
<tr>
<td>Member, Adult</td>
<td>3246</td>
</tr>
<tr>
<td>Member, Adult, 1 Child</td>
<td>3579</td>
</tr>
<tr>
<td>Member, Adult, 2 Children</td>
<td>3912</td>
</tr>
<tr>
<td>Member, Adult, 3 Children</td>
<td>4245</td>
</tr>
<tr>
<td>Member, Adult, 4 Children</td>
<td>4578</td>
</tr>
<tr>
<td>Member, Adult, 5 Children</td>
<td>4911</td>
</tr>
<tr>
<td>Member, 1 Child</td>
<td>2301</td>
</tr>
<tr>
<td>Member, 2 Children</td>
<td>2634</td>
</tr>
<tr>
<td>Member, 3 Children</td>
<td>2967</td>
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<tr>
<td>Member, 4 Children</td>
<td>3300</td>
</tr>
<tr>
<td>Member, 5 Children</td>
<td>3633</td>
</tr>
<tr>
<td>Member, 2 Adults</td>
<td>4524</td>
</tr>
<tr>
<td>Member, 3 Adults</td>
<td>5802</td>
</tr>
<tr>
<td>Member, 2 Adults, 1 Child</td>
<td>4857</td>
</tr>
<tr>
<td>Member, 2 Adults, 2 Children</td>
<td>5190</td>
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<tr>
<td>Member, 2 Adults, 3 Children</td>
<td>5523</td>
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<tr>
<td>Member, 2 Adults, 4 Children</td>
<td>5856</td>
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<tr>
<td>Member, 2 Adults, 5 Children</td>
<td>6189</td>
</tr>
<tr>
<td>Member, 3 Adults, 1 Child</td>
<td>6135</td>
</tr>
<tr>
<td>Member, 3 Adults, 2 Children</td>
<td>6468</td>
</tr>
<tr>
<td>Member, 3 Adults, 3 Children</td>
<td>6801</td>
</tr>
<tr>
<td>Member, 3 Adults, 4 Children</td>
<td>7134</td>
</tr>
<tr>
<td>Member, 3 Adults, 5 Children</td>
<td>7467</td>
</tr>
</tbody>
</table>

Please refer to clause 4.17.2 under Main Scheme Rules for the Child “21-25” contribution rates.
OPTION B+

Monthly Contributions per Income Band and Dependent Type: (if no subsidy applies):

<table>
<thead>
<tr>
<th>Option B+</th>
<th>R0 - R5,650</th>
<th>R5,651 - R9,400</th>
<th>R9,401 - R13,550</th>
<th>R13,551 - R17,350</th>
<th>R17,351 - and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>1557</td>
<td>1650</td>
<td>1665</td>
<td>1764</td>
<td>1779</td>
</tr>
<tr>
<td>Per Adult Dependant</td>
<td>1086</td>
<td>1152</td>
<td>1167</td>
<td>1236</td>
<td>1245</td>
</tr>
<tr>
<td>Per Child Dependant</td>
<td>243</td>
<td>258</td>
<td>264</td>
<td>279</td>
<td>279</td>
</tr>
</tbody>
</table>

Total Contributions per Family Size 2014 & 2015 (if no subsidy applies):

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Total Contributions 2013 &amp; 2014 (If no subsidy applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R0 - R5,650</td>
</tr>
<tr>
<td>Member</td>
<td>1557</td>
</tr>
<tr>
<td>Member, Adult</td>
<td>2643</td>
</tr>
<tr>
<td>Member, Adult, 1 Child</td>
<td>2886</td>
</tr>
<tr>
<td>Member, Adult, 2 Children</td>
<td>3129</td>
</tr>
<tr>
<td>Member, Adult, 3 Children</td>
<td>3372</td>
</tr>
<tr>
<td>Member, Adult, 4 Children</td>
<td>3615</td>
</tr>
<tr>
<td>Member, Adult, 5 Children</td>
<td>3858</td>
</tr>
<tr>
<td>Member, 1 Child</td>
<td>1800</td>
</tr>
<tr>
<td>Member, 2 Children</td>
<td>2043</td>
</tr>
<tr>
<td>Member, 3 Children</td>
<td>2286</td>
</tr>
<tr>
<td>Member, 4 Children</td>
<td>2529</td>
</tr>
<tr>
<td>Member, 5 Children</td>
<td>2772</td>
</tr>
<tr>
<td>Member, 2 Adults</td>
<td>3298</td>
</tr>
<tr>
<td>Member, 3 Adults</td>
<td>3615</td>
</tr>
<tr>
<td>Member, 2 Adults, 1 Child</td>
<td>3858</td>
</tr>
<tr>
<td>Member, 2 Adults, 2 Children</td>
<td>4152</td>
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<tr>
<td>Member, 2 Adults, 3 Children</td>
<td>4458</td>
</tr>
<tr>
<td>Member, 2 Adults, 4 Children</td>
<td>4701</td>
</tr>
<tr>
<td>Member, 2 Adults, 5 Children</td>
<td>4944</td>
</tr>
<tr>
<td>Member, 3 Adults</td>
<td>5058</td>
</tr>
<tr>
<td>Member, 3 Adults, 1 Child</td>
<td>5301</td>
</tr>
<tr>
<td>Member, 3 Adults, 2 Children</td>
<td>5544</td>
</tr>
<tr>
<td>Member, 3 Adults, 3 Children</td>
<td>5787</td>
</tr>
<tr>
<td>Member, 3 Adults, 4 Children</td>
<td>6030</td>
</tr>
</tbody>
</table>

Please refer to clause 4.17.2 under Main Scheme Rules for the Child “21-25” contribution rates
2. BENEFITS PER OPTION

OPTION A

The Scheme Tariff (ST) refers to the fee or rate set by the Scheme or agreed between the Scheme and the relevant health care provider/s for the reimbursement of benefit claims. Subject to the limitations and exclusions of benefits as stipulated in Rules 16.7 to 16.10 and in Annexure C, a member who receives benefits under this section of the Scheme Rules and/or his dependents shall be entitled to the following benefits:

1. GENERAL PRACTITIONER, HOMEOPATH AND SPECIALIST BENEFITS

(a) 100% (one hundred per cent) of the Scheme Tariff (ST) for general practitioner, homeopath and specialist consultations.

The maximum benefits collectively are:

- Member with no dependents R 7,100 per annum
- Member with one dependent R 9,570 per annum
- Member with two or more dependents R12, 160 per annum

(b) 100% (one hundred per cent) of the Scheme Tariff (ST) for all other services and procedures rendered by a general practitioner, homeopath and specialist. The maximum benefit is unlimited.
2. OPTICAL BENEFITS

a) 100% (one hundred per cent) of the Scheme Tariff (ST), for eye testing by a registered ophthalmologist or, in the case of eye testing by an optometrist, 100% (one hundred per cent) of the guide to fees of the Optometric Association of South Africa, not exceeding one eye test per financial year per beneficiary.

b) 100% (one hundred per cent) of the South African Optometric Association (SAOA) tariff, on production of a receipted account from a spectacle maker, of the cost of frames, lenses and contact lenses prescribed at a test paid for in terms of (a) above:

- The maximum benefits for lenses or contact lenses are:
  - Member with no dependents: R 2,420 per annum
  - Member with one or more dependents: R 4,790 per annum

- The maximum benefit for frames is R 1,350 per beneficiary per annum subject to the following limits:
  - Member with no dependents: R 1,350 per annum
  - Member with one or more dependents: R 2,420 per annum

c) A combined maximum benefit of R 8,440 per annum per family is payable for refractive surgery and intraocular lenses.
3. HOSPITALISATION

100% (one hundred per cent) of the Scheme Tariff (ST) for hospital and nursing home fees at the general ward high care and ICU rate as appropriate. The maximum benefit for hospitalization is R1, 503, 00.00 per annum per family.

Oncology treatment is limited to R 281,000 per annum per family Except for PMB’s.

Hospitalization for PMB is covered at 100% of cost. Pre-authorization must be obtained from the Scheme’s managed healthcare provider.

4. THEATRE FEES

100% (one hundred per cent) of the Scheme Tariff (ST) for theatre fees including anaesthetics, disinfectants, bandages and materials applied in the theatre. The maximum benefits for theatre fees are included in the hospitalization benefit of R 1,503,000 per annum per family.

5. INTERNAL PROSTHESIS

100% (one hundred per cent) of the Scheme Tariff (ST) for internal prosthesis, subject to a maximum annual benefit of R48,700 per beneficiary subject to pre-authorization except for Prescribed Minimum Benefits (PMB’S).
6. **DENTAL SERVICES**

- 100% (one hundred per cent) of the Scheme Tariff (ST) for dental services in respect of:
  
  **(a)** Ordinary fillings (such as cement, silicate, silver-alloy).
  
  **(b)** Examinations, prophylaxis, extractions, X-rays.
  
  **(c)** Dentures, repair of dentures, root treatment, crown and bridge work.
  
  **(d)** Orthodontics and maxillo-facial and oral surgery, unless for a PMB condition subject to pre-authorisation.

- The maximum benefits for **(a) and (b)** are:
  
  - Member with no dependents: R 3,550 per annum
  - Member with one dependent: R 4,560 per annum
  - Member with two dependents: R 5,580 per annum
  - Member with three dependents: R 6,410 per annum
  - Member with four or more dependents: R 7,320 per annum

- The maximum benefits for **(c) and (d)** are:
  
  - Member with no dependents: R 5,580 per annum
  - Member with one dependent: R 7,040 per annum
  - Member with two dependents: R 8,730 per annum
  - Member with three dependents: R 10,470 per annum
  - Member with four or more dependents: R 12,160 per annum

- Consultations for dental visits relating to polishing and oral examinations are limited to one visit per beneficiary every 6 months.
7. PRESCRIBED MEDICATION

- 100% (one hundred per cent) of the Single Exit Price (SEP) subject to MMAP (Maximum Medical Aid Price) for non PMB medicines, chemists’ supplies and materials for injections supplied in a hospital or nursing home plus the relevant dispensing fee.

- 100% (one hundred per cent) of the Single Exit Price (SEP) subject to MMAP (Maximum Medical Aid Price) for non PMB prescribed acute medicine plus the relevant dispensing fee.

To-Take-Out (TTO) medication prescribed on discharge from hospital will be limited to a seven (7) Day supply.

**The maximum benefits applicable to Acute Medicine are:**

- Member with no dependents  R 7,760 per annum
- Member with one dependent  R 11,260 per annum
- Member with two dependents  R 11,820 per annum
- Member with three dependents  R 12,670 per annum
- Member with four or more dependents  R 13,170 per annum

**Over the Counter (OTC) Medication**

- R 170 per script within an eight (8) day period, limited to R 1, 250 per family per annum subject to the Acute Medication benefit limits.

**Chronic Medication**

- 100% (one hundred per cent) of the Single Exit Price (SEP) for non PMB prescribed Chronic Medicine up to a maximum benefit of R 10, 580 per annum per beneficiary, including prescribed minimum benefits (PMB) which are unlimited, payable at 100% of the Single Exit Price (SEP) plus the relevant dispensing fee.

8. DIABETES MELLITUS

100% (one hundred per cent) of the Scheme Tariff (ST) subject to registration on the Scheme’s Managed Healthcare Provider.
9. HIV and AIDS

HIV and Aids costs relating to an Aids program, established per resolution passed by the Board of Trustees on 30 November 2000 will be covered, but limited to treatment in the Scheme Managed Healthcare Provider at 100% of cost for PMB related service according to a formulary and protocols.

10. PRESCRIBED MINIMUM BENEFITS (PMB)

The diagnosis, treatment and care cost of the Prescribed Minimum Benefits (PMB’s) rendered by a public hospital, shall be covered at 100% (one hundred per cent) of the cost.

The Prescribed Minimum Benefit (PMB) chronic conditions are detailed in TABLE 1 below and non-PMB chronic conditions in TABLE 2.

TABLE 1: PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)

<table>
<thead>
<tr>
<th>No.</th>
<th>Disease</th>
<th>No.</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Addison’s Disease</td>
<td>14</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>2</td>
<td>Asthma</td>
<td>15</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>3</td>
<td>Bronchiectasis</td>
<td>16</td>
<td>Haemophilia</td>
</tr>
<tr>
<td>4</td>
<td>Bipolar Mood Disorder</td>
<td>17</td>
<td>Hyperlipidaemia</td>
</tr>
<tr>
<td>5</td>
<td>Cardiomyopathy Disease</td>
<td>18</td>
<td>Hypertension</td>
</tr>
<tr>
<td>6</td>
<td>Chronic Renal Disease</td>
<td>19</td>
<td>Hypothyroidism</td>
</tr>
<tr>
<td>7</td>
<td>Cardiac Failure</td>
<td>20</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>8</td>
<td>Coronary Artery Disease</td>
<td>21</td>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>9</td>
<td>Crohn’s Disease</td>
<td>22</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>10</td>
<td>Chronic Obstructive Pulmonary Disorder</td>
<td>23</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>11</td>
<td>Diabetes Insipidus</td>
<td>24</td>
<td>Systemic Lupus Erythematosus</td>
</tr>
<tr>
<td>12</td>
<td>Diabetes Mellitus Type 1 and 2</td>
<td>25</td>
<td>Ulcerative colitis</td>
</tr>
<tr>
<td>13</td>
<td>Dysrhythmias</td>
<td>26</td>
<td>HIV and Aids</td>
</tr>
</tbody>
</table>

TABLE 2: NON-PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)

<table>
<thead>
<tr>
<th>No.</th>
<th>Disease</th>
<th>No.</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acne*</td>
<td>14</td>
<td>Iron Deficiency Anaemia*</td>
</tr>
<tr>
<td>2</td>
<td>Allergic Rhinitis**</td>
<td>15</td>
<td>Major Depression*</td>
</tr>
<tr>
<td>3</td>
<td>Alzheimer’s Disease*</td>
<td>16</td>
<td>Meniere’s Disease*</td>
</tr>
<tr>
<td>4</td>
<td>Ankylosing Spondylitis</td>
<td>17</td>
<td>Menopausal Disorder*</td>
</tr>
<tr>
<td>5</td>
<td>Benign Prostatic Hypertrophy</td>
<td>18</td>
<td>Migraine</td>
</tr>
<tr>
<td>6</td>
<td>Cushing’s Disease*</td>
<td>19</td>
<td>Myasthenia Gravis*</td>
</tr>
<tr>
<td>7</td>
<td>Cystic fibrosis</td>
<td>20</td>
<td>Osteoporosis #</td>
</tr>
<tr>
<td>8</td>
<td>Gastro-oesophageal Reflux Disorder*</td>
<td>21</td>
<td>Paraplegia, quadriplegia ##*</td>
</tr>
<tr>
<td>9</td>
<td>Gout***</td>
<td>22</td>
<td>Peripheral Vascular Disease*</td>
</tr>
<tr>
<td>10</td>
<td>Hyperkinesis (Attention Deficit Disorder)*</td>
<td>23</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>11</td>
<td>Hyperparathyroidism</td>
<td>24</td>
<td>Urinary incontinence</td>
</tr>
<tr>
<td>12</td>
<td>Hyperthyroidism</td>
<td>25</td>
<td>Stroke/Cerebrovascular Accident</td>
</tr>
<tr>
<td>13</td>
<td>Interstitial Fibrosis</td>
<td>26</td>
<td>Deep Vein thrombosis</td>
</tr>
</tbody>
</table>
The following Rules are applied with regards to the chronic medication benefits in respect of conditions as per Table 2 listed above:

The conditions marked in table 2 are subject to the authorization criteria detailed here under. Other conditions covered in table 2 will be covered at 100% of cost.

Chronic medication for Allergic Rhinitis (**) may be considered if prescribed and motivated by a specialist (ENT, paediatrician or physician).

For Gout (***) only allopurinol and probenecid-containing products may be considered.

Chronic medication for Osteoporosis (#) may only be considered on submission of a Bone Mineral Density (BMD) scans.

Chronic medication requests for certain conditions (*) may only be considered if prescribed and motivated by an appropriate specialist e.g.:

- A dermatologist prescription and motivation is required for chronic medication for acne and psoriasis
- An ENT or neurologist prescription and motivation is required for chronic medication for Meniere’s disease
- A neurologist or psychiatrist prescription and motivation is required for chronic medication for Alzheimer’s disease
- For attention deficit disorder, applications will only be considered if prescribed and motivated by a paediatrician, neurologist or psychiatrist

Medication for gastro-oesophageal reflux disease (GORD) (*) from a gastroenterologist, physician or general surgeon’s prescription and motivation is required.

Chronic medication for paraplegics and quadriplegics (###) may be considered for urinary and bowel complications.

The following conditions require special pre-authorization prior to treatment from the Scheme’s Managed Healthcare Provider. PBM benefits apply to these PMB conditions.

- Cancer (all types)
- Organ transplant

The following medicines are EXCLUSIONS FROM THE CHRONIC DISEASE BENEFIT:

- Vitamins and mineral preparations (excluding calcium for postmenopausal females and patients with hypoparathyroidism and chronic renal disease)
- Homeopathic medication
- Hypnotics and anxiolytics
- Mucolytic and decongestants
11. DIAGNOSTIC BENEFITS

100% (one hundred per cent) of the Scheme Tariff (ST) for Specialised Radiology including MRI and CT Scans, Pathology, basic Radiology and Clinical Technologist services.

The maximum combined benefit is R 26,200 per annum per family subject to PMB.

- A combined sub-limit of R12, 000 per annum per family applies to Radiology and Pathology services
- A sublimit of R11,200 per annum per family applies to Specialised Radiology (MRI & CT Scans) in and out of hospital

Benefits for specialised Radiology including MRI and CT scans are made available upon confirmation of pre-authorisation obtained from the Scheme’s preferred managed healthcare provider, except in cases of emergency and or PMB’s.

12. MATERNITY SCANS

100% (one hundred per cent) of the Scheme Tariff (ST) limited to a maximum of two (2) scans per pregnancy per annum, of which a maximum of one (1) scan can be a 3D scan. Motivation from the attending healthcare practitioner is required for additional scans.
13. BLOOD PRODUCTS

100% (one hundred per cent) of the cost of blood transfusions (cost of material, apparatus and operator’s fees). The maximum benefit is linked to the hospital benefit.

14. STEP-DOWN FACILITIES & IN LIEU OF HOSPITALISATION

100% (one hundred per cent) of the Scheme Tariff (ST) for nursing in lieu of hospitalisation and step-down facilities prescribed by a medical practitioner, for a registered nurse or enrolled auxiliary nurse with a maximum collective benefit of R35,700 per beneficiary per annum. Pre-authorisation must be obtained from the Scheme’s managed healthcare provider.

15. AUXILIARY SERVICES

100% (one hundred per cent) of the Scheme Tariff (ST) limited to R 8,100 per beneficiary per annum with a sub-limit of R 5,400 per discipline for the following services:

- Physiotherapy;
- Occupational therapy;
- Audiology;
- Psychological treatment by a registered psychologist;
- Orthotic treatment by an Orthoptist;
- Chiropractic treatment by a chiropractor;
- Podiatry;
- Treatment by a dietician; and
- Treatment by a speech therapist.

16. EXTERNAL APPLIANCES

(a) 100% (one hundred per cent) of the Scheme Tariff (ST) for oxygen equipment or other equipment prescribed by a medical practitioner unless PMB related services.

(b) 100% (one hundred per cent) of the Scheme Tariff (ST) for hearing aids and artificial limb(s), wheel chairs and other large orthopaedic appliances prescribed by a medical practitioner.

(c) The maximum annual collective benefit per family per annum in respect of (a) and (b) is R32,900. The cost of repairs to appliances will be considered up to the overall limit.
17. EMERGENCY TRANSPORT SERVICES NETCARE 911

100% (one hundred per cent) of the cost for ambulance services, fully capitated through the Designated Service Provider (Netcare 911)

Ambulance authorisation procedure

In all instances, where possible, call Netcare 911. In the case of an inter-hospital transfer, when you are admitted to hospital, please inform the admitting hospital that you are a Netcare 911 member and that any transfers must be done through 082 911.

What to do with the vehicle stickers you receive?

Netcare 911 encourages you to place the vehicle window sticker you receive from your medical scheme on one of the side windows of your motor vehicle. This will alert any emergency service on the scene that you are a member of Netcare 911.

Your benefits include

Health-on-Line – emergency telephonic medical advice and information

Assistance and advice is just a phone call away through Netcare 911’s Health-on-Line, which provides emergency as well as non-emergency telephonic medical advice to members by qualified nursing sisters via the Netcare 911 24-hour Emergency Operations Centre and in accordance with current clinical best practice.

Emergency medical response by road or air from scene of medical emergency
Immediate response, using the most appropriate and closest road or air medical resource, staffed by doctors, nurses and paramedics administering instant, life-saving treatment, resuscitation and stabilisation.
Netcare 911 at your service

Netcare 911 is South Africa’s largest private emergency service, with highly skilled medical staff and a national network of emergency vehicles.

Netcare 911’s doctor-based helicopter and fixed wing aeroplanes can be dispatched, should it be required.

By simply dialling 082 911 from any landline or cellular phone, you and your dependants have access to excellent emergency medical care.

IMPORTANT CONTACT DETAILS

Netcare 911 Head Office: 010 209 8911
Emergencies: 082 911
Health-on-Line: 082 911
Website: www.netcare911.co.za
E-mail: customer.service@netcare.co.za

Points to remember when calling Netcare 911:

- Dial 082 911 if there is a medical emergency.
- Give your name and the telephone number you are calling from.
- Give a brief description of what has happened and try to explain how serious the situation is.
- Give the address or location of the incident as well as the nearest cross streets or other landmarks to assist paramedics to reach the scene as quickly as possible.
- Please, if possible, tell the Call Taker which medical scheme you belong to.
- Do not put the phone down until the controller has disconnected.
BENEFIT EXCLUSIONS

With due regard to the prescribed minimum benefits the following treatments and services are excluded from the benefits provided in terms of this option.

1. All slimming preparations and preparations used to treat obesity. (E.g. Slimming Mixture, Slimming Injections and Diet Program)
2. Contact lens solutions.
3. Food supplements including baby food and special milk preparations. (Except for babies delivered by a HIV-positive mother for the first six months)
4. Homeopathic and herbal medicines and household remedies or other miscellaneous household products of a medical nature.
5. Medicines to specifically treat infertility (Except for PMBs)
6. Medicines used to specifically treat alcoholism and habit forming substances. (Except for PMBs)
7. Anabolic steroids.
8. Diabetes test strips.(except for PMB’s)
10. Wilfully self-inflicted injuries, e.g. attempted suicide. (Except for PMBs)
11. Injury arising from sport or speed contests.
13. Injuries sustained during participation in a strike, during illegal picketing or riot or during physical struggle.
14. Mental disorders. (Except for PMBs)
15. Contraceptives Preparations and Devices
16. Syringes and Needles – only on prescription
17. Aphrodisiacs
18. Cosmetic preparations medicated or otherwise
19. Immunosuppresses – pre-authorisation required
20. Stimulant laxatives
21. Anti-diarrheal micro-organisms – only on prescription
22. Immune sera and immunoglobulin’s – pre-authorisation required
23. Allergens
24. Haematinics – iron supplements – pre-authorisation required
25. Vitamin products (except for patients diagnosed with HIV/AIDS)
26. Essentially fatty acid preparations and combinations – only on prescription
27. Over the counter reading glasses
28. Stoma therapy products – pre-authorisation required
29. Botox injections – pre-authorisation required
30. Gold fillings
## Option A 2015 Benefit Limits

### In-Hospital

#### Hospital Benefit Limit

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>General ward * Subject to pre-authorisation</td>
<td>100% of the Scheme tariff in a general ward Limited to R 1,503,000 per family per annum</td>
</tr>
<tr>
<td>Medical tests in hospital * Subject to pre-authorisation</td>
<td>100% of the Scheme tariff Subject to overall hospital limit</td>
</tr>
<tr>
<td>Specialised Radiology (MRI and CT Scans) In- and Out-of-Hospital. * Subject to pre-authorisation</td>
<td>Limit of R 11,200 per family per annum. (Except for PMB)</td>
</tr>
<tr>
<td>Blood Transfusions</td>
<td>100% of cost Subject to overall hospital limit</td>
</tr>
<tr>
<td>Maternity * Includes: Confinement, Foetal scans in hospital &amp; midwife confinements</td>
<td>100% of the Scheme tariff Subject to overall hospital limit</td>
</tr>
<tr>
<td>Internal Prosthesis</td>
<td>100% of the Scheme tariff Subject to pre-authorisation Subject to limit of R 48,700 per beneficiary per annum, except for PMB's</td>
</tr>
<tr>
<td>Renal Dialysis * Subject to pre-authorisation &amp; state protocols</td>
<td>100% of the Scheme tariff Subject to overall hospital limit</td>
</tr>
<tr>
<td>Step-down facilities * Subject to pre-authorisation and referral by a medical practitioner</td>
<td>100% of Scheme tariff Limited to R 35,700 per beneficiary Benefit usage in lieu of hospitalisation</td>
</tr>
</tbody>
</table>

### Related Hospital Benefits

#### Disease Management Programmes

<table>
<thead>
<tr>
<th>Programme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV and AIDS * Subject to registration on Diabetic Programme</td>
<td>100% of the Scheme tariff Treatment in line with prescribed minimum benefits (PMB) protocols</td>
</tr>
<tr>
<td>Diabetes * Subject to pre-authorisation</td>
<td>100% of the Scheme tariff Treatment in line with prescribed minimum benefits (PMB) protocols</td>
</tr>
<tr>
<td>Oncology * Subject to pre-authorisation</td>
<td>100% of the Scheme tariff Limited to R 281,000 per family per annum except for PMBs</td>
</tr>
</tbody>
</table>

### Day to Day Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations for GP’s, Homeopaths &amp; Specialist</td>
<td>100% of the Scheme tariff Limited to: M0 = R 7,100 M1 = R 9,570 M2+ = R 12,160</td>
</tr>
<tr>
<td>Radiology &amp; Pathological Services</td>
<td>100% of the Scheme tariff Sub-limit of R 12,000 for Radiology and Pathology services per family per annum</td>
</tr>
</tbody>
</table>
### Acute medication
Dispensing fees paid in line with the applicable legislation

<table>
<thead>
<tr>
<th>OTC Medication: R170 per script within an eight day period, limited to R1,250 per family per annum. Subject to the Acute Medication benefit limits.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chronic medication</strong></td>
</tr>
<tr>
<td>100% of SEP plus PDF</td>
</tr>
<tr>
<td>Limited to:</td>
</tr>
<tr>
<td>M0 = R 7,760</td>
</tr>
<tr>
<td>M1 = R 11,260</td>
</tr>
<tr>
<td>M2 = R 11,820</td>
</tr>
<tr>
<td>M3 = R 12,670</td>
</tr>
<tr>
<td>M4+ = R 13,170</td>
</tr>
</tbody>
</table>

**Subject to 100% of MMAP tariffs**

### External Appliances
(Includes oxygen equipment; hearing aids; artificial limb; wheelchairs & other equipment)

100% of the Scheme tariff
Limited to R 32,900 per member per family
Repairs are subject to clinical protocols

### Auxiliary Services
Includes:
- Occupational Therapy
- Chiropractor
- Podiatry
- Physiotherapy
- Orthoptist
- Audiometry
- Dietician
- Psychology
- Speech Therapy

100% of the Scheme tariff
Limited to R 8,100 per beneficiary per annum, Subject to sub-limit of R 5,400 per discipline

### Ambulances
100% of cost To be covered by Netcare 911.

### Dentistry

**Basic dentistry**
(Examinations; X-rays; extractions; ordinary fillings; prophylaxis)

100% of the Scheme tariff Limited to:
- M0 = R 3,550
- M1 = R 4,560
- M2 = R 5,580
- M3 = R 6,410
- M4 = R 7,320

**Consultations for dental visits relating to polishing and oral examinations limited to 1 visit per beneficiary every 6 months**

100% of the Scheme tariff, Limited to:
- M0 = R 5,580
- M1 = R 7,040
- M2 = R 8,730
- M3 = R 10,470
- M4+ = R 12,160

**Specialised dentistry**
(Maxillo Facial; Oral Surgery; Orthodontics; root treatment; Dentures; Crowns & Bridge work; Repair of dentures)

100% of the Scheme tariff
Limited to:
- M0 = R 5,580
- M1 = R 7,040
- M2 = R 8,730
- M3 = R 10,470
- M4+ = R 12,160

### Optical

**Eye test**
100% of SAOA tariff
Limited to one test per beneficiary per annum

**Frames**
*Subject to a sub-limit of R 1,350 per beneficiary per annum*

100% of SAOA tariff
Limited to:
- M0 = R 1,350
- M1+ = R 2,420

**Lenses or Contact Lenses**
100% of SAOA tariff
Limited to:
- M0 = R 2,420
- M1+ = R 4,790

**Refractive Surgery & Intraocular Lenses**
(Refractive surgery subject to pre-authorisation and clinical protocols)

100% of the Scheme tariff
Limited to R 8,440 per member family
OPTION B+

The Scheme Tariff (ST) refers to the fee or rate set by the Scheme and the relevant health care provider/s for the reimbursement of benefit claims. Subject to the limitations and exclusions of benefits as stipulated in Rules 16.7 to 16.10 and in Annexure C, a member who receives benefits under this section of the Rules and/or his dependents shall be entitled to the following benefits.

1. GENERAL PRACTITIONER BENEFITS

(a) 100% (100 hundred per cent) of the Scheme Tariff (ST) for general practitioner consultations.

The maximum benefits collectively are:
- Member with no dependents: R 2,130 per annum
- Member with one dependent: R 3,260 per annum
- Member with two or more dependents: R 4,330 per annum

(b) 100% (one hundred per cent) of the Scheme Tariff (ST) for other services and procedures rendered by a general practitioner.

2. SPECIALISTS BENEFITS (INCLUDING PHYSIOTHERAPISTS AND OCCUPATIONAL THERAPISTS)

100% (100 hundred per cent) of the Scheme Tariff (ST) for Specialist, Physiotherapist and Occupational Therapist consultations limited to three (3) visits or R2,420 per beneficiary per annum and five (5) visits or R3,380 per family per annum.

- No benefit is payable where the member self-refers without consulting a general practitioner first
- Consultations for PMBs are or subject to PMB Protocols
- Pre-authorisation from the Scheme’s managed healthcare provider is required for each visit and for any other referrals or procedures.
- Subject to pre-authorization by the Scheme’s Managed Healthcare Provider, 2 additional Gynaecologist visits are provided per beneficiary per pregnancy per annum.
- In-hospital physiotherapy is limited to R7,260 per family per annum.
3. OPTICAL BENEFITS

(a) 100% (one hundred per cent) of the Scheme Tariff (ST), for eye testing by a registered ophthalmologist or, in the case of eye testing by an optometrist, 100% (one hundred per cent) of the guide to fees of the Optometric Association of South Africa, not exceeding one eye test per financial year per beneficiary.

(b) 100% (one hundred per cent) of the SAOA tariff, on production of a receipted account from a spectacle maker, of the cost of frames, lenses and contact lenses prescribed at a test paid for in terms of (a) above:

The maximum collective benefit for frames, lenses, contact lenses and eye test are:

- Member with no dependants: R 1,180 per annum
- Member with one or more dependants: R 2,420 per annum

4. HOSPITALISATION

100% (one hundred per cent) of the Scheme Tariff (ST) for hospital and nursing home fees at a general ward high care and ICU rate as appropriate. The maximum benefit limit for hospitalization is R 736,000 per annum per family.

Hospitalization for PMB including Oncology and Renal Dialysis is covered at 100% of cost all public hospitals and private hospitals. Pre-authorization must be obtained from the Scheme’s Managed Healthcare Provider.
5. THEATRE FEES

100% (one hundred per cent) of the Scheme Tariff (ST) for theatre fees including anaesthetics, disinfectants, bandages and materials applied in the theatre. The maximum benefits for theatre fees are included in the hospitalization benefit of R 736, 000 per annum per family.

6. INTERNAL PROSTHESIS

100% (one hundred per cent) of the Scheme Tariff (ST) for internal prosthesis, subject to a maximum annual benefit per family of R 22, 400 per family per annum except for PMBs.

7. DIAGNOSTIC BENEFITS

100% (one hundred per cent) of the Scheme Tariff (ST) to the maximum combined benefit limit of R22,400 per annum per family (except for PMB) for Specialised Radiology including MRI and CT scans, Medical Technology, basic Radiology and Pathology services.
- A combined sub-limit of R9,000 per annum per family applies to radiology and pathology services.
- Radiology and Pathology In-hospital is subject to the overall hospital limit

8. CLINICAL TECHNOLOGISTS

100% (one hundred per cent) of the Scheme Tariff (ST) limited to R16,300 per family per annum.

9. BLOOD PRODUCTS

100% (one hundred per cent) of the Scheme Tariff (ST) for blood transfusions limited to R16, 300 per family per annum. Transportation costs are included in the limit.
10. SURGICAL APPLIANCES AND EXTERNAL PROSTHESIS

100% (one hundred per cent) of the Scheme Tariff (ST) for surgical and orthopaedic appliances and external prosthesis. The maximum annual benefit is R7,260 per annum per family.

11. STEP DOWN FACILITIES & NURSING IN LIEU OF HOSPITALISATION

100% (one hundred per cent) of the Scheme Tariff (ST) Step-Down Facilities & Nursing in Lieu of Hospitalisation prescribed by a Medical Practitioner, for a Registered Nurse or Enrolled Auxiliary nurse with a maximum collective benefit of R16,300 per family per annum. Pre-authorisation must be obtained from the Scheme’s Managed Healthcare Provider.

12. DENTAL SERVICES

![Dental Services Image](image)

a) 100% (one hundred per cent) of the Scheme Tariff (ST) for dental services in respect of:
   - Ordinary fillings (such as cement, silicate, silver-alloy)
   - Examinations, prophylaxis, extractions, X-rays
   - Dentures, repair of dentures, root treatment, crown and bridge work
   - Orthodontics and maxillo-facial and oral surgery, unless for a PMB condition and subject to Pre-authorization

b) Consultations for dental visits relating to polishing and oral examinations are limited to one visit per beneficiary every 6 months.

c) Maxillo-facial surgery is limited To R12, 100 per family per annum subject to overall hospital limit.

d) Hospitalisation for dental services is limited to only trauma cases, treatment of impacted 3rd molars for children under 7 years of age at day theatres

- The maximum benefit limits for (a), (b), (c) and (d) are:
  - Member with no dependents R 1, 180 per annum
  - Member with one dependents R 1, 800 per annum
  - Member with two dependents R 2, 080 per annum
  - Member with three dependents R 2, 420 per annum
  - Member with four dependents R 2, 700 per annum
13. PRESCRIBED MEDICATION

(a) 100% (one hundred per cent) of the Single Exit Price (SEP) subject to MMAP (Maximum Medical Aid Price) for non PMB medicines, chemists’ supplies and materials for injections supplied in a hospital or nursing home plus the relevant dispensing fee.

(b) 100% (one hundred per cent) of the Single Exit Price (SEP) subject to MMAP (Maximum Medical Aid Price) for non PMB prescribed acute medicine plus the relevant dispensing fee.

(c) The maximum benefits applicable to acute medicine are:
   - Member with no dependents: R 1,740 per annum
   - Member with one dependents: R 2,980 per annum
   - Member with two or more dependents: R 4,160 per annum

(d) 100% (one hundred per cent) of the Single Exit Price (SEP) for PMB prescribed chronic medicine plus the relevant dispensing fee at Pharmacy Network Provider

(e) Over the Counter (OTC) Medication
   R 160 per script within an eight (8) day period, limited to R 1,060 per family per annum. Subject to the Acute Medication benefit limits
14. HIV and AIDS

HIV and Aids costs relating to an Aids program, established per resolution passed by the Board of Trustees on 30 November 2000 will be covered at 100% of cost for PMB related service according to a formulary and protocols 100% of Scheme tariff for non PMB treatment

15. DIABETES MELLITUS

100% (one hundred per cent) of the Scheme Tariff (ST) subject to registration on the Scheme’s Managed Healthcare Provider.

16. PRESCRIBED MINIMUM BENEFITS

The diagnosis, treatment and care cost of the Prescribed Minimum Benefits (PMB’s) rendered by a public hospital, and Private Hospital, shall be covered at 100% (one hundred per cent) of the cost.

<table>
<thead>
<tr>
<th>TABLE 1: PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Addison’s Disease</td>
</tr>
<tr>
<td>2. Asthma</td>
</tr>
<tr>
<td>4. Bipolar Mood Disorder</td>
</tr>
<tr>
<td>5. Cardiomyopathy Disease</td>
</tr>
<tr>
<td>6. Chronic Renal Disease</td>
</tr>
<tr>
<td>7. Cardiac Failure</td>
</tr>
<tr>
<td>8. Coronary Artery Disease</td>
</tr>
<tr>
<td>9. Crohn’s Disease</td>
</tr>
<tr>
<td>10. Chronic Obstructive Pulmonary Disorder</td>
</tr>
<tr>
<td>12. Diabetes Mellitus Type 1 and 2</td>
</tr>
<tr>
<td>13. Dysrhythmias</td>
</tr>
</tbody>
</table>

The following conditions require special pre-authorization prior to treatment from the Scheme’s managed healthcare provider. PBM benefits apply to these PMB conditions.

- Cancer
- Organ Transplant

The following medicines are excluded from the Chronic Disease Benefit:

- Vitamins and mineral preparations (excluding calcium for postmenopausal females and patients with hypoparathyroidism and chronic renal disease) unless medically necessary
- Homeopathic Medication
- Hypnotic and anxiolytics
- Mucolytics and decongestants
17. EMERGENCY TRANSPORT SERVICES NETCARE 911

100% (one hundred per cent) of the cost for ambulance services, fully capitated through the Designated Service Provider (Netcare 911)

Ambulance authorisation procedure

In all instances, where possible, call Netcare 911. In the case of an inter-hospital transfer, when you are admitted to hospital, please inform the admitting hospital that you are a Netcare 911 member and that any transfers must be done through 082 911.

What to do with the vehicle stickers you receive?

Netcare 911 encourages you to place the vehicle window sticker you receive from your medical scheme on one of the side windows of your motor vehicle. This will alert any emergency service on the scene that you are a member of Netcare 911.

Your benefits include

Health-on-Line – emergency telephonic medical advice and information

Assistance and advice is just a phone call away through Netcare 911’s Health-on-Line, which provides emergency as well as non-emergency telephonic medical advice to members by qualified nursing sisters via the Netcare 911 24-hour Emergency Operations Centre and in accordance with current clinical best practice.

Emergency medical response by road or air from scene of medical emergency
Immediate response, using the most appropriate and closest road or air medical resource, staffed by doctors, nurses and paramedics administering instant, life-saving treatment, resuscitation and stabilisation.
Netcare 911 at your service

Netcare 911 is South Africa’s largest private emergency service, with highly skilled medical staff and a national network of emergency vehicles.

Netcare 911’s doctor-based helicopter and fixed wing aeroplanes can be dispatched, should it be required.

By simply dialling 082 911 from any landline or cellular phone, you and your dependants have access to excellent emergency medical care.

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IMPORTANT CONTACT DETAILS

Netcare 911 Head Office: 010 209 8911
Emergencies: 082 911
Health-on-Line: 082 911
Website: www.netcare911.co.za
E-mail: customer.service@netcare.co.za

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Points to remember when calling Netcare 911:

- Dial 082 911 if there is a medical emergency.
- Give your name and the telephone number you are calling from.
- Give a brief description of what has happened and try to explain how serious the situation is.
- Give the address or location of the incident as well as the nearest cross streets or other landmarks to assist paramedics to reach the scene as quickly as possible.
- Please, if possible, tell the Call Taker which medical scheme you belong to.
- Do not put the phone down until the controller has disconnected.
18. BENEFIT EXCLUSIONS

With due regard to the prescribed minimum benefits the following treatments and services are excluded from the benefits provided in terms of this option.

1. All slimming preparations and preparations used to treat obesity. (E.g. Sliming Mixture, Sliming Injections and Diet Program)
2. Contact lens solutions.
3. Food supplements including baby food and special milk preparations. (Except for babies delivered by a HIV-positive mother for the first six months)
4. Homeopathic and herbal medicines and household remedies or other miscellaneous household products of a medical nature.
5. Medicines to specifically treat infertility. (Except for PMBs)
6. Medicines used to specifically treat alcoholism and habit forming substances. (Except for PMBs)
7. Anabolic steroids.
8. Diabetes test strips. (Except for PMBs)
10. Wilfully self-inflicted injuries, e.g. attempted suicide. (Except for PMBs)
11. Injury arising from sport or speed contests. (Except for PMBs)
13. Injuries sustained during participation in a strike, during illegal picketing or riot or during physical struggle (Except for PMBs).
14. Mental disorders. (Except for PMBs)
15. Contraceptives Preparations and Devices
16. Syringes and Needles – only on prescription
17. Aphrodisiacs
18. Cosmetic preparations medicated or otherwise
19. Immunosuppressive – pre-authorisation required
20. Stimulant laxatives
21. Anti-diarrheal micro-organisms – only on prescription
22. Immune sera and immunoglobulin’s – pre-authorisation required
23. Allergens
24. Haematinics – iron supplements – pre-authorisation required
25. Vitamin products (except for patients diagnosed with HIV/AIDS)
26. Essentially fatty acid preparations and combinations – only on prescription
27. Over the counter reading glasses
28. Stoma therapy products – pre-authorisation required
29. Botox injections – pre-authorisation required
30. Gold fillings
# Option B+ 2015 Benefit Limits

## In-Hospital Benefits

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalisation</td>
<td>Overall limit R 736,000 per family.</td>
</tr>
<tr>
<td>Surgical and non-Surgical procedures</td>
<td>Subject to overall hospital limit.</td>
</tr>
<tr>
<td>Medicine and Materials in Hospital</td>
<td>Subject to overall annual hospital limit.</td>
</tr>
<tr>
<td>Physiotherapy in Hospital</td>
<td>Limited to R 7,260 per family per annum.</td>
</tr>
<tr>
<td>Clinical Technologists</td>
<td>Limited to R 16,300 per family per annum.</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Limited to R 16,300 per family per annum. Includes transport costs.</td>
</tr>
<tr>
<td>Basic Radiology, Pathology and medical technology</td>
<td>In-hospital is subject to the overall hospital limit</td>
</tr>
<tr>
<td>Specialised Radiology (MRI &amp; CT Scan)</td>
<td>Combined benefit limit of R22,400 in and out of hospital per annum per family (except for PMB) for Specialised Radiology including MRI and CT scans, Medical Technology, basic Radiology and Pathology services. A combined out of Hospital sub-limit of R9,000 per annum per family applies to radiology and pathology services.</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Hospitalisation only for trauma and impacted 3rd molars. Only children aged under 7 years. Subject to pre-authorisation Day Theatres and DSPN hospitals only.</td>
</tr>
<tr>
<td>Maxillofacial Surgery</td>
<td>Limited to R 12,100 per family per annum, subject to pre-authorisation</td>
</tr>
<tr>
<td>Maternity and Neonates</td>
<td>Subject to overall hospital limit.</td>
</tr>
<tr>
<td>Surgical and Orthopaedic appliances</td>
<td>Limited to R 7,260 per family per annum.</td>
</tr>
<tr>
<td>Oxygen</td>
<td>Subject to overall hospital limit.</td>
</tr>
<tr>
<td>Renal Dialysis (acute and chronic)</td>
<td>All Public Hospitals and limited Private Hospitals. Limited to PMB’s only.</td>
</tr>
<tr>
<td>Oncology</td>
<td>All Public Hospitals and limited Private Hospitals. Limited to PMB’s only.</td>
</tr>
<tr>
<td>Internal Prosthesis</td>
<td>Limited to R 22,400 per family per annum.</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>Limited to PMB’s only.</td>
</tr>
<tr>
<td>External Prosthesis</td>
<td>Subject to Surgical and Orthopaedic appliances.</td>
</tr>
<tr>
<td>Step Down and Home Nursing * Subject to Pre-authorization</td>
<td>Limited to R 16,300 per family per annum.</td>
</tr>
<tr>
<td>Emergency Transport</td>
<td>100% of cost To be covered by Netcare 911.</td>
</tr>
<tr>
<td>Auxiliary Services Includes:</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy; Chiropractor; Orthoptist; Audiometry; Psychology; Podiatry; Dietician; Speech Therapy</td>
<td>Only covered in Hospital on pre authorisation and if a PMB</td>
</tr>
<tr>
<td>*Appliances</td>
<td>Only covered in Hospital except for PMB</td>
</tr>
<tr>
<td>Benefit Type</td>
<td>Details</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Out of Hospital Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>GP Consultations</td>
<td><strong>100% of the Scheme tariff.</strong> Combined limit</td>
</tr>
<tr>
<td></td>
<td><strong>Limited to:</strong></td>
</tr>
<tr>
<td></td>
<td>- <strong>M0</strong> = R 2,130</td>
</tr>
<tr>
<td></td>
<td>- <strong>M1</strong> = R 3,260</td>
</tr>
<tr>
<td></td>
<td>- <strong>M2+</strong> = R 4,330</td>
</tr>
<tr>
<td>Emergency Visits</td>
<td><strong>Unlimited without co-payment provided the episode meets the requirements of the definition on an emergency medical condition. Any registered emergency medical facility. Excluding facility fees.</strong></td>
</tr>
<tr>
<td>Specialist Consultations, Physiotherapists and Occupational Therapists</td>
<td><strong>Limited to 3 visits or R 2,420 per beneficiary and 5 visits or R 3,380 per family. PMB consultations subject to PMB protocols. Pre-Authorisation required for each visit and any other referrals or procedures.</strong></td>
</tr>
<tr>
<td>* No benefit where member self-refers without consulting a general practitioner first.</td>
<td></td>
</tr>
<tr>
<td>Acute medication</td>
<td><strong>100% of SEP plus PDF</strong></td>
</tr>
<tr>
<td>OTC: R160 per script, with an overall limit of R 1,060 per family per annum</td>
<td><strong>Limited to:</strong></td>
</tr>
<tr>
<td></td>
<td>- <strong>M0</strong> = R 1,740</td>
</tr>
<tr>
<td></td>
<td>- <strong>M1</strong> = R 2,980</td>
</tr>
<tr>
<td></td>
<td>- <strong>M2+</strong> = R 4,160</td>
</tr>
<tr>
<td></td>
<td><strong>Subject to MMAP tariffs</strong></td>
</tr>
<tr>
<td>Chronic medication</td>
<td><strong>Chronic Medication for the treatment of 26 PMB CDL conditions only.</strong></td>
</tr>
<tr>
<td>* Subject to Registration and PMB Protocols</td>
<td></td>
</tr>
<tr>
<td>Basic Radiology, Pathology, Medical Technology and Specialised Radiology (MRI and CT Scan)</td>
<td><strong>Combined limit of R 22,400 for in and out-of-hospital per family per annum with a sub-limit of R9,000 for Radiology and Pathology.</strong></td>
</tr>
<tr>
<td>Optical Services (Eye Test, Lenses, Contact Lenses and Frames)</td>
<td><strong>100% of SAOA tariffs</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Limited to:</strong></td>
</tr>
<tr>
<td></td>
<td>- <strong>M0</strong> = R 1,180</td>
</tr>
<tr>
<td></td>
<td>- <strong>M1</strong> = R 2,420</td>
</tr>
<tr>
<td>Dental Services (Basic and Specialised) Specialised dentistry subject to pre-authorisation</td>
<td><strong>100% of the Scheme tariff, Limited to:</strong></td>
</tr>
<tr>
<td></td>
<td>- <strong>M0</strong> = R 1,180</td>
</tr>
<tr>
<td></td>
<td>- <strong>M1</strong> = R 1,800</td>
</tr>
<tr>
<td></td>
<td>- <strong>M2</strong> = R 2,080</td>
</tr>
<tr>
<td></td>
<td>- <strong>M3</strong> = R 2,420</td>
</tr>
<tr>
<td></td>
<td>- <strong>M4</strong> = R 2,700</td>
</tr>
<tr>
<td>HIV and Aids</td>
<td><strong>100% of cost. Case managed in line with prescribed minimum benefit (PMB) protocols.</strong></td>
</tr>
</tbody>
</table>
ANNEXURE B
PREScribed MINIMUM BENEFITS

1. Designation of service providers

The medical scheme contracts with service provider(s) for the delivery of prescribed minimum benefits in the following categories for both Option A and Option B+:

- Hospitalisation: No DSP
- Out of hospital services: No DSP
- Diabetes: Sanlam Health Management(SHM)
- Pharmacy Network: Sanlam Health Management(SHM)
- Medicine management: Sanlam Health Management(SHM)
- Clinical Management: Sanlam Health Management(SHM)
- HIV/AIDS management: Sanlam Health Management(SHM)
- Dental Service: Supplementary Health Services (SHS)
- Emergency Services: Net Care 911

2. Prescribed minimum benefits obtained from designated service providers

100% of the costs in respect of diagnosis, treatment and care costs of prescribed minimum benefit conditions if those services are obtained from a designated service provider.

3. Prescribed minimum benefits voluntarily obtained from other providers

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the benefit payable in respect of such service is subject to:

- a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the designated service provider been used.

4. Prescribed minimum benefits involuntarily obtained from other providers

a. If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the medical scheme will pay 100% of the cost in relation to those prescribed minimum benefit conditions.

b. For the purposes of paragraph a, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if –

   I. the service was not available from the designated service provider or would not be provided without unreasonable delay;
   II. immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or
   III. there was no designated service provider within reasonable proximity to the beneficiary’s ordinary place of business or personal residence.

c. Except in the case of an emergency medical condition, preauthorisation shall be obtained by a member prior to involuntarily obtaining a service from a provider other than a designated service provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph b are applicable.
5. Medication

a) Where a prescribed minimum benefit includes medication, the Scheme will pay 100% of the Single Exit Price (SEP) of that medication if that medication is obtained from a designated service provider or is involuntarily obtained from a provider other than a designated service provider plus relevant dispensing fee.

b) Where a prescribed minimum benefit includes medication and that medication is voluntarily obtained from a provider other than a Pharmacy Network, a co-payment equal to the difference between the Single Exit Price (SEP) of the drug and the reference price of the formulary drug will apply plus relevant dispensing fee.

The list of PBM chronic conditions in respect of Option A and Option B+ is as follows:

|----|-----------------------|-----------|-------------------|------------------------|---------------------------|--------------------------|---------------------|------------------------|----------------|-----------------------------|----------------|--------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|-------------------------|----------------|----------------|----------------|

ANNEXURE C
EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. EXCLUSIONS

Unless otherwise decided by the Board, expenses incurred by a member or dependant in terms of Rule 16.8 as well as in connection with any of the following, but excluding any prescribed minimum benefits, or preferred provider benefits which are described in Annexure B of the Rules, shall not be paid by the Scheme:

1.1 All costs of whatsoever nature incurred for treatment of sickness conditions or injuries sustained by a member or a dependant and for which any other party is liable. The member is however entitled to such benefits as would have applied under normal conditions, provided that on receipt of payment, in respect of medical expenses, the member will reimburse the Scheme any money paid by the Scheme in respect of this benefit.

1.2 The testing of eyes except when undertaken by a medical practitioner or registered ophthalmologist or optometrist.

1.3 Treatment for wilful self-injury, illness or injury resulting from attempted suicide, or injury sustained during participation in a strike, during illegal picketing or riot except for PMB.

1.4 Treatment for illness or injury resulting from participation in sport for monetary reward or prize money except for PMB.
1.5 Treatment for illness or injury resulting from participation in any contest of speed, excluding amateur athletics except for PMB.
1.6 Purchase or hire of medical, surgical or other appliance except as provided for in Annexure B.
1.7 Purchase of medicine, bandages, dressings and other similar aids not included in a prescription from a medical practitioner or a dentist.
1.8 Operations, procedures and treatment performed upon and at the desire of the member or dependant in respect of whom the claim is made but which are not essential, in the opinion of the medical practitioner nominated by the Scheme and such member’s or dependant’s medical practitioner in consultation, for the treatment of the illness in respect of which the claim is made.
1.9 Treatment for Educational problems
1.10 Prescription sunglasses

2. LIMITATION OF BENEFITS

The limitations below apply to members to whom Option A and Option B+ benefits apply, but do not apply to the prescribed minimum benefits in respect of services provided at any public hospital or designated service provider.

2.1 In a case of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant consulting a specialist whom the Board may nominate in consultation with the attending medical practitioner. If such a specialist’s advice is not acted upon, no further benefits shall be granted in respect of such illness.

2.2 In a case where a specialist is consulted without the recommendation of a general practitioner, the benefit may be limited to the amount that would have been paid to a general practitioner for the same service: provided that an eye specialist, gynaecologist may be consulted without the recommendation of a general practitioner.

2.3 In a case where major osteo-surgery is required i.e. Joint Replacements or Spinal Fusions, the Board shall have the right to insist upon a member or dependant having to obtain a second medical opinion.

2.4 Participation in the Diabetic programme is subject to pre-registration.

2.5 Should a beneficiary suffer from any of the chronic conditions listed under Paragraph 9 of Annexure B and wishes to obtain the relevant benefits, he/she will be obliged to participate in the Chronic Disease Management Programme provided by the Scheme.

GLOSSARY

- CMS - Council for Medical Schemes
- PDF - Pharmacy Dispensing Fee
- PMB - Prescribed Minimum Benefits
- SEP - Single Exit Price
- TTO - Treatment to Take Out
- OAL - Overall Annual Limit
- OTC - Over the Counter
- SAOA - South African Optometric Association
- MMAP - Maximum Medical Aid Price
RULES OF RAND WATER MEDICAL SCHEME
(Registration No. 1201) (Established 1 January 1918)

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RULES

1. NAME

The name of the scheme is Rand Water Medical Scheme, hereinafter referred to as the "Scheme".

2. LEGAL PERSONA

The Scheme, in its own name, is a body corporate, capable of suing and of being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of the Medical Schemes Act and regulations and these rules.

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 522 Impala Road, Glenvista, Johannesburg but the Board may transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.

4. DEFINITIONS

In these Rules, a word or expression defined in the Medical Schemes Act (Act 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context -

(a) A word in the singular number includes the plural, and vice versa.
(b) The following expressions have the following meanings:

4.1 "Act",
The Medical Schemes Act (Act No 131 of 1998), and the regulations framed thereunder.

4.2 "Adult"
A person other than the spouse, partner or child of the member who is dependent on the member for family care and support, is related to the member whether by affinity or consanguinity (blood, marriage, adoption etc) and who is registered in terms of these rules as an adult dependant including, but not limited to:

4.2.1 the child dependant of a member who is over the age of 21 (twenty-one) years and who is:
   4.2.1.1 a full-time student aged 25 (twenty-five) years or less; or
   4.2.1.2 mentally or physically handicapped;

4.2.2 the relative, whether by affinity or consanguinity (blood, marriage, adoption etc.), of the member;

4.2.3 any other person who is recognised by the Board as an adult dependant for the purposes of these rules

4.3 "Approval",
Prior written approval of the Board or its authorised representative.
4.4  "Auditor",

4.5  "Authorised representative",
The principal Officer or any member of the Board of Trustees, authorised by the Board to act on its behalf.

4.6  "Beneficiary",
A member or a person admitted as a dependant of a member.

4.7  "Board",
The Board of Trustees constituted to manage the scheme in terms of the Act and these Rules.

4.8  "Child",
A member's natural child, or a stepchild or legally adopted child or a child in the process of being legally adopted or a child who has been placed in the custody of the member or his/her spouse or partner and for whom the member has a duty of support and who is not a beneficiary of any other medical scheme.

4.9  "Condition specific waiting period"
A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 (twelve) month period ending on the date on which an application for membership was made.

4.10 "Continuation member"
A member who retains his/her membership of the Scheme in terms of Rule 6.2 or a dependant who becomes a member of the Scheme in terms of Rule 6.3.

4.11 "Contracted fee"
The fee determined in terms of an agreement between the scheme and a service provider or group of providers in respect of the payment of relevant health services.

4.12 "Contribution"
In relation to a member, the amount, exclusive of interest, paid by or in respect of the member and his registered dependants if any, as membership fees.

4.13 "Council"
The Council for Medical Schemes as contemplated in the Act.

4.14 "Cost"
In relation to a benefit, the net amount payable in respect of a relevant health service.

4.15 "Creditable coverage"
Any period during which a late joiner was —
4.15.1 a member or a dependant of a medical scheme;
4.15.2 a member or a dependant of an entity doing the business of a medical scheme which, at the time of his/her membership of such entity, was exempt from the provisions of the Act;
4.15.3 a uniformed employee of the South African National Defence Force, or a dependant of such employee, who received medical benefits from the South African National Defence Force; or
4.15.4 a member or a dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 years.

4.16 "Dependant"
4.16.1 A member’s spouse or partner who is not a member or a registered dependant of a member of a medical scheme.
4.16.2 A member’s dependent child who is not a member or a registered dependant of a member of a medical scheme.
4.16.3 The immediate family of a member in respect of whom the member is liable for family care and financial support; and who is not a member or a registered dependant of a member of a medical scheme.
4.16.4 Any other person who is recognised by the Board as a dependant for purposes of these Rules.

4.17 "Dependent"
4.17.1 In relation to a child, a child under the age of 21 (twenty-one) years, who is not in receipt of a regular remuneration of more than the maximum social pension per month;
4.17.2 In relation to a child who is over the age of 21 (twenty-one) years, but not over the age of 25 (twenty-five) years, who is not self-supporting and who is registered as a full-time and or part-time student at a recognised institution for higher learning, provided that evidence of such registration is submitted to the Board at the commencement of each academic year. Contributions are subject to adult dependant rates.
4.17.3 In relation to a child over the age of 21 (twenty-one) years who, due to a mental or physical disability is not self-supporting and is dependent on the member for family care and support;
4.17.4 In relation to a dependant other than the member’s spouse or partner, a dependant who is not in receipt of a regular remuneration of more than the maximum social pension per month.

4.18 “Designated service provider”
A healthcare provider or group of providers selected by the scheme as preferred provider/s to provide to the members, diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.

4.19 “Domicilium citandi et executandi”
The member’s chosen physical address at which notices in terms of rules 11 and 13 as well as legal process, or any action arising therefrom, may be validly delivered and served.

4.20 “Emergency medical condition”
The sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s life in serious jeopardy.
4.21 “Employee”
An employee is defined as a person who is employed as a permanent, full-time or part-time employee and a person who is employed in terms of a fixed-term contract of no less than 3 years (continuous).

4.22 “Employer”,
Rand Water established in terms of Section B of the Water Services Act (Act 108 of 1997).

4.23 “General waiting period”
A maximum period of 3 (three) months during which a beneficiary is not entitled to claim any benefits.

4.24 “Income”,
For the purposes of calculating contributions in respect of -

4.24.1 A member who is an employee – the substantive salary paid to an employee by the employer. Salary shall not include any interest or dividend from investment or any allowance received while acting temporarily in any post, the value of free quarters or any allowance in lieu thereof, or any bonus, commission, overtime payment, travelling allowance or cost of living allowance.

4.24.2 A member who registers a spouse or partner as a dependant — the higher of member or spouse’s or partner’s earnings.

4.24.3 A continuation member — gross monthly pension received from the Superannuation Fund, or a calculated amount he would have received as a monthly pension had he been a member of the Superannuation Fund and opted to take a monthly pension subject to such amount being increased annually at the same percentage increase granted to the Rand Water pensioners.

4.25 “late joiner”
An applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding 3 (three) consecutive months since 1 April 2001.

4.26 “Member”,
Any person who is admitted as a member of the Scheme in terms of these rules.

4.27 “Member family”,
The member and all the registered dependants.

4.28 “Scheme Tariff (ST)”
The fee or rate set by the Scheme or as agreed between the Scheme and the relevant health care provider/s for the reimbursement of benefit claims.

4.29 “Partner”
A person with whom the member has a committed relationship based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.
4.30 "Preferred Provider"
Service providers appointed by the Scheme from time to time to provide specified medical services to the Scheme which are outlined in an appropriate service agreement between the preferred provider and the Scheme.

4.31 “Prescribed Minimum Benefits”
The benefits contemplated in section 29(1)(o) of the Act and consist of the provision of the diagnosis, treatment and care costs of —
   a) the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and
   b) any emergency medical condition.

4.32 “Prescribed Minimum Benefit condition”
A condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations or any emergency medical condition.

4.33 "Registrar",
The Registrar or Deputy Registrar/s of Medical Schemes appointed in terms of Section 18 of the Act.

4.34 “Relevant health care provider”
A person providing a relevant health service

4.35 “Relevant health service”
Means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object —
   a) the physical or mental examination of that person;
   b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
   c) the giving of advice in relation to any such defect, illness or deficiency;
   d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;
   e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or
   f) nursing or midwifery, and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy;

4.36 “Social pension”,

4.37 "Spouse",
The person to whom the member is married in terms of any law or custom.
5. **OBJECTS**

The objects of the Scheme are to:

a) undertake liability, in respect of its members and their dependants, in return for a contribution or premium –

b) to make provision for the obtaining of any relevant health service.

c) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and/or

d) to render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service, or by any person in association with, or in terms of an agreement with the Scheme.

6. **MEMBERSHIP**

6.1 Eligibility

Subject to Rule 8, membership of the Scheme is restricted to:

◆ Employment or former employment by the employer or his predecessor or successor in title as defined in these Rules, and is either voluntary or compulsory, depending on the employee’s conditions of employment.

6.2 Retirees

6.2.1 A member shall retain his/her membership of the Scheme with his/her registered dependants, if any, in the event of his/her retiring from the service of his/her employer or his/her employment being terminated by his/her employer on account of age, ill health or other disability.

6.2.2 The Scheme shall inform the member at the time of retirement of his/her right to continue his/her membership and of the contribution payable from the date of retirement or termination of his/her employment on account of ill-health. Unless such member notifies the Scheme in writing of his/her desire to terminate his/her membership, he/she shall continue to be a member.

6.3 Dependants of deceased members

6.3.1 The dependants of a deceased member who are registered with the Scheme as his/her dependants at the time of such member’s death, shall be entitled to continued membership of the Scheme without any new restrictions, limitations or waiting periods.

6.3.2 The Scheme shall inform the dependant of his/her right to membership and of the contributions payable in respect thereof. Unless such person informs the Board in writing of his/her intention not to become a member, he/she shall be admitted as a member of the Scheme.

6.3.3 Such a member’s membership terminates if he/she becomes a member or a dependant of a member of another medical scheme.

6.3.4 Where a child dependant/s has been orphaned, the eldest child may be deemed to be the member, and any younger siblings, the child dependant/s. Such membership shall terminate if such a member shall

6.3.4.1 Become a member of, of is accepted as a dependant of a member of another registered medical scheme;
6.3.4.2 Inform the Scheme in writing of his intention not to become a member, or;
6.3.4.3 Reach the age of 21 (twenty-one) years, unless the criteria set out in 4.16.2 and 4.16.3 is met.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of dependants

7.1.1 A member may apply for the registration of his/her dependants at the time that he/she applies for membership in terms of Rule 8.
7.1.2 If a member applies to register a new born or newly adopted child as a dependant and submits the birth certificate or a certified copy thereof within 30 (thirty) days of the date of birth or adoption of the child, increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption. However, failure to comply with this Rule may render such child ineligible for the full period of non-compliance.
7.1.3 Should

7.1.3.1 a new member not register any eligible dependants immediately upon his admission to the Scheme or;
7.1.3.2 a member at any time acquire an eligible dependant whether by birth, adoption, marriage or otherwise, and not register such new dependant within 30 days of the eligibility of such dependant, the Scheme shall subject to the provisions contained in Rule 8.4 and 8.5., be entitled to impose, upon later registration as a dependant, a waiting period (general or condition specific) during which period no benefit shall accrue to such dependant, but subscriptions shall be paid to the Scheme.
7.1.4 If a member who marries subsequent to joining the Scheme, applies within 30 (thirty) days of the date of such marriage to register his spouse as a dependant, his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of marriage and benefits will accrue as from the date of commencement of membership. The spouse shall not qualify for benefits until such time as the member qualifies for benefits.
7.1.5 In the event of any person becoming eligible for registration as a dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.4, the member may apply to the Scheme for the registration of such person as a dependant, whereupon the provisions of Rule 8 shall apply mutatis mutandis.

7.2 De-registration of Dependents

7.2.1 A member shall inform the Scheme within 30 (thirty) days of the occurrence of any event which results in any one of his/her dependants no longer satisfying the conditions in terms of which he/she may be a dependant.
7.2.2 When a dependant ceases to be eligible to be a dependant, he/she shall no longer be deemed to be registered as such for the purpose of these Rules or entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise.
8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

8.1 A minor may become a member with the consent of his/her parent or guardian.

8.2 No person may be a member of more than one medical scheme or a dependant:
   8.2.1 of more than one member of a particular medical scheme, or
   8.2.2 members of different medical schemes, or
   8.2.3 claim or accept benefits in respect of himself or any of his dependants from any
       medical scheme in relation to which he is not a member

8.3 Prospective members shall, prior to admission, complete and submit the application forms,
   required by the Scheme, together with satisfactory evidence in respect of himself/herself
   and his/her dependants, of age, income, state of health and of any prior membership or
   admission as dependant of any other medical scheme. The Scheme may require an
   applicant to provide the Scheme with a medical report in respect of any proposed
   beneficiary in respect of a condition for which medical advice, diagnosis, care of
   treatment was recommended or received within the 12 (twelve) month period ending
   on the date on which an application for membership was made. The costs of any
   medical tests or examinations required to provide such medical report will be paid for by
   the Scheme. The Scheme may however designate a provider to conduct such tests or
   examinations.

8.4 Waiting periods

   8.4.1 The Scheme may impose upon a person in respect of whom an application is made
       for membership or admission as a dependant, and who was not a beneficiary of a
       medical scheme for a period of at least 90 (ninety) days preceding the date of
       application-
       8.4.1.1 a general waiting period of up to 3 (three) months; and
       8.4.1.2 a condition-specific waiting period of up to 12 (twelve) months

   8.4.2 The Scheme may impose upon any person in respect of whom an application is
       made for membership or admission as a dependant, and who was previously a
       beneficiary of a medical scheme for a continuous period of up to 24 (twenty four)
       months, terminating less than 90 (ninety) days immediately prior to the date of
       application-
       8.4.2.1 a condition-specific waiting period of up to 12 (twelve) months, except
       in respect of any treatment or diagnostic procedures covered
       within the prescribed minimum benefits
       8.4.2.2 in respect of any person contemplated in this subrule, where the
       previous medical scheme had imposed a general or condition-specific
       waiting period, and such waiting period had not expired at the time of
       termination, a general or condition-specific waiting period for the
       unexpired duration of such waiting period imposed by the former
       medical scheme.

8.4.3 The Scheme may impose upon any person in respect of whom an application is
       made for membership or admission as a dependant, and who was previously a
       beneficiary of a medical scheme for a continuous period of more than 24 (twenty
       four) months, terminating less than 90 (ninety) days immediately prior to the date
       of application, a general waiting period of up to 3 (three) months, except in respect
of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

8.5 No waiting period may be imposed on:

8.5.1 a person in respect of whom application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme, terminating less than 90 (ninety) days immediately prior to the date of application, where the transfer of membership is required as a result of-

8.5.1.1 change of employment; or

8.5.1.2 an employer changing or terminating the medical scheme of its employees, in which case such a transfer shall occur at the beginning of the financial year, or reasonable notice must have been furnished to the Scheme to which an application is made for such transfer to occur at the beginning of the financial year.

Where the former medical scheme had imposed a general or condition-specific waiting period in respect of persons referred to in this Rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme

8.5.2 a beneficiary who changes from one benefit option to another within the Scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied;

8.5.3 a child dependant born during the period of membership;

8.6 The registered dependants of a member must participate in the same benefit option as the member.

8.7 Should a member elect not to register his eligible dependants, on admission to membership such dependants will upon future application for registration as dependants of the member be subject to the application of Rules 8.3 to 8.5.

8.8 Every member will, on admission to membership, receive a detailed summary of these Rules which shall include contributions, benefits, limitations, the member’s rights and obligations. Members and their dependants, and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming are bound by these Rules as amended from time to time.

8.9 A member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which he/she may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of any benefit, or any right in respect of such benefit under these rules, if a member assigns, transfers, cedes, pledges or hypothecates such benefit

9. TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

If the members of a medical scheme who are members of that scheme by virtue of their employment by a particular employer, terminate their membership of such scheme with the object of obtaining membership of this Scheme, the Board will admit as a member, without a waiting period, any member of such first-mentioned scheme who is a continuation member by virtue
MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

10. Every member shall be furnished with a membership card, containing such particulars as may be prescribed. This card must be exhibited to the supplier of a service on request. It remains the property of the scheme and must be returned to the scheme on termination of membership.

10.2 In submitting a receipt for such card a member shall be deemed –
   a) to have bound himself/herself and his/her dependants to comply with these Rules and any amendments thereof;
   b) to have authorized the Board to deduct from the moneys due to him/her by the Scheme, by the employer, by the Rand Water Superannuation Fund, or by Rand Water Provident Fund, surcharges or any other amounts due by him/her to the Scheme;
   c) to have authorized practitioners to disclose to the Scheme the nature of any illness in respect of which a claim is made.

10.3 A member who loses his/her membership card and is issued with a duplicate card, or a member who fails to surrender his/her membership card on termination, shall be charged R50.00.

10.4 The utilisation of a membership card by any person other than the member or his/her registered dependants, with the knowledge or consent of the member or his/her dependants, is not permitted and is construed as an abuse of the privileges of membership of the Scheme.

10.5 On termination of membership or on de-registration of a dependant, the Scheme must, within 30 (thirty) days of such termination, or at any time on request, furnish such person with a certificate of membership and cover, containing such particulars as may be prescribed.

11. CHANGE OF ADDRESS OF MEMBER

A member must notify the Scheme within 30 (thirty) days of any change of address including his/her domicilium citandi et executandi. The Scheme shall not be held liable if a member’s rights are prejudiced or forfeited as a result of the member’s neglecting to comply with the requirements of this Rule.

12. TERMINATION OF MEMBERSHIP

12.1 Resignation
   12.1.1 A member who, in terms of his conditions of employment is required to be a member of the Scheme, may not terminate his membership while he remains an employee without the prior written consent of his employer.
   12.1.2 A member who resigns from the service of the employer shall, on the date of such termination, cease to be a member and all rights to benefits shall thereupon cease, except for claims in respect of services rendered prior thereto.
   12.1.3 A member whose employment is terminated for reasons related to the operational requirements of the employer may, in the discretion of the Board, be
allowed continued membership for a period of up to six months after termination of employment, provided that if such member should obtain alternative employment, his/her membership shall terminate with immediate effect.

12.2 Death

Membership of a member terminates on his/her death.

12.3 Failure to pay amounts due to the Scheme

If a member fails to pay amounts due to the Scheme, his/her membership may be terminated as provided in these Rules.

12.4 Abuse of privileges, False claims, Misrepresentation and Non-disclosure of Factual information.

The Board may exclude from benefits or terminate the membership of a beneficiary whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information. In such event he/she may be required by the Board to refund to the Scheme any sum which, but for his/her abuse of the benefits or privileges of the Scheme, would not have been disbursed on his/her behalf.

13. CONTRIBUTIONS

13.1 The total monthly contributions payable to the Scheme by or in respect of a member are as stipulated in Annexure A. It shall be the responsibility of the member to notify the Scheme of changes in income that may necessitate a change in contribution in terms of Annexure A hereto.

13.2 Contributions shall be due monthly in arrears and be payable by not later than the third day of each month. Where contributions or any other debt owing to the Scheme, have not been paid within 30 (thirty) days of the due date, the Scheme shall have the right –

13.2.1 to suspend all benefit payments in respect of claims which arose during the period of default, and

13.2.2 to give the member and/or employer written notice at his/her/its domicilium citandi and executandi that if contributions or such other debts are not paid within 21 (twenty one) days of posting of such notice, membership may be cancelled.

A notice sent by prepaid registered post to the member at his/her domicilium citandi et executandi shall be deemed to have been received by the member on the 7th day after the date of posting. In the event that the member fails to nominate a domicilium citandi et executandi, the member’s postal or residential address on his/her application form shall be deemed to be his/her domicilium citandi et executandi.

13.3 In the event that payments are brought up to date and provided benefits have not been cancelled in accordance with Rule 13.2.2, benefits shall be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interest on the arrear amount at the prime overdraft rate of the Scheme’s bankers. If such payments are not brought up to date, no benefits shall be due to the member from the date of default and any such benefit paid will be recovered by the Scheme.
13.4 Unless specifically provided for in the rules in respect of savings accounts, no refund of any assets of the Scheme or any portion of a contribution shall be paid to any person where such member’s membership or cover in respect of any dependant terminates during the course of a month.

13.5 In terms of employees who are on a Total Cost to Company remuneration package, the total contribution of 3/3 (three thirds) will be deducted from the employee.

14. LIABILITIES OF EMPLOYER AND MEMBER

14.1 The liability of the employer towards the Scheme is limited to any amounts payable in terms of any agreement between the employer and the Scheme.

14.2 The liability of a member to the Scheme is limited to the amount of his/her unpaid contributions together with any sum disbursed by the Scheme on his/her behalf or on behalf of his/her dependants which has not been repaid to the Scheme.

14.3 In the event of a member ceasing to be a member, any amount still owing by such member is a debt due to the Scheme and recoverable by it.

15. CLAIMS PROCEDURE

15.1 Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement as prescribed.

15.2 If an account, statement of claim is correct or where a corrected account, statement, or claim is received, as the case may be, the Scheme must in addition to the payment contemplated in Section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars:
   a. The name and the membership number of the member;
   b. The name of the supplier of service;
   c. The final date of service rendered by the supplier of service on the account or statement which is covered by the payment;
   d. The total amount charged for the service concerned; and
   e. The amount of the benefit awarded for such service.

15.3 In order to qualify for benefits, any claim must, unless otherwise arranged, be signed and certified as correct and must be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered.

15.4 Where a member has paid an account, he/she shall, in support of his/her claim, submit a receipt.

15.5 Accounts for treatment of injuries or expenses recoverable from third parties, must be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained.

15.6 Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the member and the relevant health care provider, within 30 (thirty) days after receipt thereof and state the reasons for such an opinion. The Scheme shall afford such member and provider the
opportunity to submit such corrected account or statement to the Scheme within 60 (sixty) days following the date from which it was returned for correction.

16. BENEFITS

16.1 Members are entitled to benefits during a financial year, as per Annexure B, and such benefits extend through the member to his/her registered dependants. A member must, on admission, elect to participate in any one of the available options, detailed in Annexure B.

16.2 A member is entitled to change from one to another benefit option subject to the following conditions:

16.2.1 The change may be made only with effect from 1 January of any financial year. The Board may, in its absolute discretion, permit a member to change from one to another benefit option on any other date, provided that the member may change to another option in the case of midyear contribution increases or benefit changes.

16.2.2 Application to change from one benefit option to another must be in writing and lodged with the Scheme within the period notified by the Scheme, provided that the member has had at least 30 (thirty) days prior notification of any intended changes in benefits or contributions for the next year.

16.3 The Scheme shall, where an account has been rendered, pay any benefit due to a member, either to that member or to the supplier of the relevant health service who rendered the account, within 30 (thirty) days of receipt of the claim pertaining to such benefit.

16.4 Any benefit option in Annexure B covers the cost of services rendered in respect of the prescribed minimum benefits, in accordance with Appendix 2 of the Regulations

16.5 No limitations or exclusions will be applied to the prescribed minimum benefits.

16.6 Unless otherwise provided for or decided by the Board, expenses incurred in connection with any of the following will not be paid by the Scheme:

16.6.1 All costs for operations, medicines, treatment and procedures for cosmetic purposes.

16.6.2 Holidays for recuperative purposes.

16.6.3 Purchase of the following unless prescribed:
- Medicines not registered with the Medicines Control Council;
- toiletries and beauty preparations;
- slimming products;
- homemade remedies; and
- alternative medicines.

16.6.4 All costs that are more than the annual maximum benefit to which a beneficiary is entitled in terms of the rules of the Scheme.

16.6.5 Charges for appointments which a beneficiary fails to keep.
16.6.6 Costs for services rendered by —
- persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
- any institution, nursing home or similar institution not registered in terms of any law, except a state or provincial hospital.

16.7 Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

16.8 Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month’s supply for every such prescription or repeat thereof.

17. PAYMENT OF ACCOUNTS

17.1 The payment of accounts is restricted to the maximum amount of the benefit entitlement and the Scheme Tariff in terms of the applicable benefit and option selected.

17.2 The Scheme may, whether by agreement or not with any supplier or group of suppliers of a service, pay the benefit to which the member is entitled, directly to the supplier or group of suppliers who rendered the service.

17.3 All accounts in respect of services rendered in terms of the prescribed minimum benefits at a public hospital as well as services provided in terms of a preferred provider contract will be settled by the Scheme in full and with the provider direct without any limitations.

17.4 Where the Scheme has paid an account or portion of an account or any benefit to which a member is not entitled, whether payment is made to the member or to the supplier of service, the amount of any such overpayment is recoverable by the Scheme.

17.5 Notwithstanding the provisions of this Rule, the Scheme has the right to pay any benefit directly to the member concerned.

17.6 The Scheme will be responsible for claims and/or cost incurred under the benefits and limits specific to the membership within the borders of the Republic of South Africa only.

18 GOVERNANCE

18.1 The affairs of the Scheme must be managed according to these Rules by a Board consisting of 10(ten) persons who are fit and proper to be trustees.

18.2 Five of such trustees must be elected by members from amongst members hereinafter also referred to as employee representatives. The other five trustees shall be appointed by the employer as employer representatives.

18.3 Trustees serve terms of office of three years.

18.4 Following persons are not eligible to serve as members of the Board:
   18.4.1 A person under the age of 21 (twenty-one) years;
18.4.2 an employee, director, officer, consultant, or contractor of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator;

18.4.3 a broker

18.4.4 the Principal Officer of the Scheme; and

18.4.5 the auditor of the Scheme.

18.5 Retiring members of the Board are eligible for re-election provided no person shall serve more than two consecutive terms and no more than a total of three terms.

18.6 Nominations to fill vacancies, signed by a proposer and seconder in good standing with the Scheme, must be signed by the candidate signifying his/her consent to stand for election and, must be submitted to the scheme together with a current curriculum vitae by 31 March, of the year concerned and the election must be carried out by ballot by the members prior to the Annual General Meeting of the Scheme. Election results will be announced at the Annual General Meeting.

18.7 The Board may fill by appointment any vacancy arising during the term of office of a member of the Board due to such member resigning in terms of Rule 18.14 or ceasing to hold office in terms of Rule 18.15. A person so appointed must retire at the first ensuing Annual General Meeting and that meeting must fill the vacancy for the unexpired period of office of the vacating member of the Board.

18.8 The employer shall have the right to appoint an alternate to each Employer Representative to act during the absence of that Representative.

The members will elect an alternate from among their number to each Employee Representative to act during the absence of that Representative.

18.9 The Board may co-opt a knowledgeable person to assist it in its deliberations provided that such person shall not have a vote.

18.10 A quorum is constituted by a number of members of the Board physically present at a meeting of that Board, which number shall be not less than half of the members of the Board plus one.

18.11 The Board must elect from its number the Chairperson and Vice-chairperson.

18.12 In the absence of the Chairperson and Vice-chairperson, the Board members present must elect one of their numbers to preside.

18.13 Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the Chairperson has a casting vote in additional to his/her deliberative vote.

18.14 A member of the Board may resign at any time by giving written notice to the Board.

18.15 A member of the Board ceases to hold office if -

18.15.1 he becomes mentally ill or incapable of managing his/her affairs;

18.15.2 he/she is declared insolvent or has surrendered his/her estate for the benefit of his/her creditors;

18.15.3 he/she is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;
18.15.4 he/she is removed by the court from any office of trust on account of misconduct;
18.15.5 he/she is disqualified under any law from carrying on his profession;
18.15.6 he/she ceases to be an appointee by the employer, or being a Board member elected by members of the scheme, he/she ceases to be a member of the Scheme;
18.15.7 he/she absents himself/herself from three consecutive meetings of the Board without the permission of the Chairperson;
18.15.8 he/she is removed from office by the Council in terms of Section 46 of the Act; or
18.15.9 he/she is removed from office in terms of Rule 18.20

18.16 The Board must meet at least once every 2 (two) months or at such intervals as it may deem necessary.

18.17 The Chairperson may convene a special meeting should the necessity arise. Any 2 members of the Board may request the Chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.

18.18 The Board may, subject to participation by sufficient members to form a quorum, discuss and resolve matters by telephonic or electronic conferencing means and may adopt resolutions on that basis.

18.19 Members of the Board shall not be entitled to any remuneration, honorarium or any other fee in respect of services rendered in their capacity as members of the Board.

18.20 A member of the Board who acts in a manner which is seriously prejudicial to the interests of beneficiaries of the medical scheme may be removed by the Board, provided that –
18.20.1 before a decision is taken to remove the member of the Board, the Board shall furnish that member with full details of the evidence which the Board has at its disposal regarding the conduct complained of, and allow such member a period of not less than 30 days in which to respond to the allegations;
18.20.2 the resolution to remove that member is taken by at least two thirds of the members of the Board;
18.20.3 the member shall have recourse to disputes procedures of the scheme or complaints and appeal procedures provided for in the Act.

19. DUTIES OF BOARD OF TRUSTEES

19.1 The Board is responsible for the proper and sound management of the Scheme, in terms of these Rules.

19.2 The Board must act with due care, diligence, skill and in good faith.

19.3 Members of the Board must avoid conflicts of interests, and must declare any interest they may have in any particular matter serving before the Board.

19.4 The Board must apply sound business principles and ensure the financial soundness of the Scheme.
19.5 The Board must appoint a Principal Officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the proper execution of the business of the Scheme, and shall determine the terms and conditions of service of the Principal Officer and of any person employed by the Scheme.

19.6 The Chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.

19.7 The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the scheme.

19.8 The Board must ensure that proper control systems are employed by and on behalf of the scheme.

19.9 The Board must ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the Rules.

19.10 The Board must take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and the Rules.

19.11 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.

19.12 The Board may obtain expert advice on legal, accounting and business matters as required, or on any other matter of which the members of the Board may lack sufficient expertise.

19.13 The Board must ensure that the Rules and the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.

19.14 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any beneficiary’s state of health.

19.15 The Board must approve all disbursements.

19.16 The Board must cause to be kept in safe custody, in a safe or strong room at the registered office of the Scheme or with any financial institution approved by the Board, any mortgage bond, title deed or other security belonging to or held by the scheme, except when in the temporary custody of another person for the purposes of the Scheme.

19.17 The Board must make such provision as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.

19.18 The Board must disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme, as prescribed.

20. POWERS OF BOARD

The Board has the power -
20.1 To cause the termination of the services of any employee of the Scheme;
20.2 to take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfilment of the Scheme's obligations under such appointments;

20.3 to appoint a committee consisting of such Board members and other experts as it may deem appropriate;

20.4 to appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme. The terms and conditions of such appointment must be contained in a written contract, which complies with the requirements of the Act and the regulations.

20.5 to appoint, contract with and compensate any accredited managed health care organisation in the prescribed manner;

20.6 to purchase movable and immovable property for the use of the scheme or otherwise, and to sell it or any of it;

20.7 to let or hire movable or immovable property;

20.8 to sell movable and immovable property of the Scheme subject to sound business practice and fair value principles;

20.9 in respect of any monies not immediately required to meet current charges upon the Scheme and subject to the provisions of the Act, and in the manner determined by the Board, to invest or otherwise deal with such moneys upon security and to realise, re-invest or otherwise deal with such monies and investments;

20.10 with the prior approval of the Council, to borrow money for the Scheme from the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage;

20.11 subject to the provisions of any law, to cause the Scheme, whether on its own or in association with any person, to establish or operate any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or any similar institution, in the interests of the members of the Scheme;

20.12 to donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the beneficiaries;

20.13 to contribute to any fund conducted for the benefit of employees of the Scheme;

20.14 to reinsure obligations in terms of the benefits provided for in these Rules;

20.15 to authorise the Principal Officer and/or such members of the Board as it may determine from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme;

20.16 to contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes;
20.17 In general, do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these Rules.

21. DUTIES OF PRINCIPAL OFFICER AND STAFF

21.1 The staff of the Scheme must ensure the confidentiality of all information regarding its members.

21.2 The Principal Officer is the Executive Officer of the Scheme and as such shall ensure that:

21.2.1 He/she acts in the best interests of the members of the scheme at all times.
21.2.2 The decisions and instructions of the Board are executed without unnecessary delay.
21.2.3 Where necessary, there is proper and appropriate communication between the Scheme and those parties affected by the decisions and instructions of the Board.
21.2.4 He/she keeps the Board sufficiently and timeously informed of the affairs of the Scheme concerning any matters relating to the duties of the Board as stated in Section 57(4) of the Act.
21.2.5 He/she keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of Section 57(6) of the Act.
21.2.6 He/she does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he/she at all times observes the authority of the Board in its governance of the Scheme.

21.3 The Principal Officer shall be the Accounting Officer of the Scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the Scheme.

21.4 The Principal Officer shall ensure the carrying out of all of his/her duties as are necessary for the proper execution of the business of the Scheme. He/she shall attend all meetings of the Board, and any other duly appointed committee where his/her attendance may be required, and ensure proper recording of the proceedings of all meetings.

21.5 The Principal Officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.

21.6 The Principal Officer shall keep full and proper records of all moneys received and expenses incurred by, and of all assets, liabilities and financial transactions of the Scheme.

21.7 The Principal Officer shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

21.8 The following persons are not eligible to be a Principal Officer:

21.8.1 An employee, director, officer, consultant or contractor of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator.
21.8.2 A broker.

21.9 The provisions of Rules 18.15.1-18.15.5 apply mutatis mutandis to the Principal Officer.
22. INDEMNIFICATION AND FIDELITY GUARANTEE

22.1 The Board and any officer of the Scheme is indemnified by the Scheme against all proceedings, costs and expenses incurred by reason of any claim against/by the scheme, not arising from their negligence, dishonesty or fraud.

22.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers.

23. FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme extends from the 1st (first) day of January to the 31st (thirty-first) day of December of that year.

24. BANKING ACCOUNT

The Scheme must establish and maintain a bank account under its direct control with a registered commercial bank. All moneys received must be deposited directly to the credit of such account. All payments must be made either by electronic transfer, tape exchange or by cheque under the joint signature of not less than two persons duly authorised by the Board.

25. AUDITOR AND AUDIT COMMITTEE

25.1 An auditor (who must be approved in terms of Section 36 of the Act) must be appointed by resolution at each Annual General Meeting, to hold office from the conclusion of that meeting to the conclusion of the next Annual General Meeting.

25.2 The following persons are not eligible to serve as auditor of the Scheme:

25.2.1 a member of the Board;
25.2.2 an employee, officer or contractor of the Scheme;
25.2.3 an employee, director, officer or contractor of the Scheme’s administrator, or of the holding company, subsidiary, joint venture or associate of the administrator;
25.2.4 a person not engaged in public practice as an auditor;
25.2.5 a person who is disqualified from acting as an auditor in terms of the Companies Act, 1973.

25.3 Whenever for any reason an auditor vacates his/her office prior to the expiration of the period for which he/she has been appointed, the Board must within 30 (thirty) days appoint another auditor to fill the vacancy for the unexpired period.

25.4 If the members of the Scheme at a General Meeting fail to appoint an auditor required to be appointed in terms of this Rule, the Board must within 30 (thirty) days make such appointment, and if it fails to do so, the Registrar may at any time do so.

25.5 The auditor of the Scheme has a right of access to the books, records, accounts, documents and other effects of the Scheme at all times and is entitled to require from the Board and the officers of the Scheme such information and explanations as he deems necessary for the performance of his/her duties.

25.6 The auditor must report to the members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in General Meeting.

25.7 The Board shall appoint an audit committee in the manner as prescribed in the Act.
26. GENERAL MEETINGS

26.1 Annual General Meeting

26.1.1 The Annual General Meeting of members must be held not later than 30 June of each year on a date which may be shown to permit reasonable attendance by members.

26.1.2 The notice convening the Annual General Meeting, containing the agenda, the annual financial statements, auditor’s report and annual report, must be furnished to members at least 21 (twenty-one) days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such meeting, provided that the notice procedure followed by the Board was reasonable.

26.1.3 At least 15 (fifteen) members of the Scheme present in person constitute a quorum. If a quorum is not present after a lapse of 30 (thirty) minutes from the time fixed for the commencement of the meeting, the meeting must be postponed to a date determined by the Board with notice of such postponed meeting being reissued in terms of Rule 26.1.2, and members then present constitute a quorum.

26.1.4 The financial statements and reports specified in Rule 26.1.2 must be laid before the meeting.

26.1.5 Notices of motions to be placed before the annual general meeting must reach the Principal Officer not later than 7 (seven) days prior to the date of the meeting.

26.2 Special General Meeting

26.2.1 The Board may call a Special General Meeting of members if it is deemed necessary.

26.2.2 On the requisition of at least 100 members of the Scheme, the Board must cause a Special General Meeting to be called within 30 (thirty) days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the requisitionists and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed.

26.2.3 The notice convening the Special General Meeting, containing the agenda, must be furnished to members at least 14 (fourteen) days before the date of the meeting provided that the notice procedure followed by the Board was reasonable.

26.2.4 At least 50 members present shall constitute a quorum. If a quorum is not present after a lapse of 30 (thirty) minutes from the time fixed for commencement of the meeting, the meeting shall be cancelled.

27. VOTING AT MEETINGS

27.1 Every member who is present at a General Meeting of the Scheme has the right to vote, or may, subject to this rule, appoint another member of the scheme as proxy to attend, speak and vote in his/her stead.

27.2 The instrument appointing the proxy must be in writing, in a form determined by the Board and must be signed by the member and the person appointed as the proxy.
27.3 The Chairperson must determine whether the voting must be by ballot or by a show of hands. In the event of the votes being equal, the Chairperson, if he/she is a member, has a casting vote in addition to his/her deliberative vote.

28. COMPLAINTS AND DISPUTES

28.1 Members may lodge their complaints, in writing, to the Scheme. The Scheme or its administrators shall also provide a dedicated toll free telephone number to be used for dealing with telephonic enquiries and complaints.

28.2 All complaints received in writing will be responded to by the Scheme in writing within 30 (thirty) days of receipt thereof.

28.3 A disputes committee of three members, who may not be members of the Board, employees of the administrator, must be appointed by the Board to serve a term of office of 3 (three) years. At least one of such members shall be a person with legal expertise.

28.4 Any dispute, which may arise between a member, prospective member, former member or a person claiming by virtue of such member and the scheme or an officer of the scheme, must be referred by the Principal Officer to the disputes committee for adjudication.

28.5 On receipt of a request in terms of this rule, the Principal Officer must convene a meeting of the disputes committee by giving not less than 21 (twenty-one) days’ notice in writing to the complainant and all the members of the disputes committee, stating the date, time, and venue of the meeting and particulars of the dispute.

28.6 The disputes committee may determine the procedure to be followed.

28.7 The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative.

28.8 An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the disputes committee. Such appeal must be in the form of an affidavit directed to Council and shall be furnished to the Registrar not later than 3 (three) months after the date on which the decision concerned was made, or such further period as the Council may for good cause shown allow, after the date on which the decision concerned was made.

28.9 The operation of any decision which is the subject of an appeal under Rule 28.8 shall be suspended pending the decision of the Council on such appeal.

29. TERMINATION OR DISSOLUTION

29.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution.

29.2 Members in a General Meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for members to decide by ballot whether the Scheme must be liquidated.

29.3 Pursuant to a decision by members taken in terms of Rule 29.2 the Principal Officer must, in consultation with the Registrar, furnish to every member a memorandum containing the
reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper.

29.4 Every member must be requested to return his/her ballot paper duly completed before a set date. If at least 50% (fifty per cent) of the members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, subject to the approval of the Registrar, a competent person as liquidator.

29.5 If the employer is wound up or ceases to carry on its operations the Board shall seek the advice of the Registrar about the Scheme.

30. AMALGAMATION AND TRANSFER OF BUSINESS

30.1 The Scheme may, subject to the provisions of Section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person. The Board must arrange for members to be furnished with an exposition of the proposed transaction for consideration and to decide by ballot whether the proposed transaction should be proceeded with or not.

30.2 If at least 50% (fifty per cent) of the members return their ballot papers duly completed and if the majority thereof are in favour of the amalgamation or transfer, the transaction may be concluded in the prescribed manner.

30.3 The Registrar may, on good cause shown, ratify a lower percentage.

31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 Any beneficiary must on request and on payment of a fee of 50 (fifty) cent per copy, be supplied by the Scheme with a copy of the following documents:
   31.1.1 The rules of the Scheme.
   31.1.2 The latest audited annual financial statements, returns, Trustees reports and auditors report of the Scheme and the accompanying management accounts in respect of the Scheme and all of its benefit options.

31.2 A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in Rule 31.1 and to make extracts therefrom.

31.3 This rule shall not be construed to restrict a person’s rights in terms of the Promotion of Access to Information Act, Act No 2 of 2000.

32. AMENDMENT OF RULES

32.1 The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

32.2 No amendment, rescission or addition which affects the objects of the Scheme or which increases the rates of contribution or decreases the extent of benefits of the Scheme or of any particular benefit option by more than the National Treasury projection of CPIX plus 3% in respect of any financial year, is valid unless it has been approved by a majority of members present in a general meeting or by ballot.
32.3 Members must be furnished with a copy of such amendment within 14 (fourteen) days after registration thereof. Should a member’s rights, obligations, contributions or benefits be amended, he/she shall be given 30 (thirty) days advance notice of such change.

32.4 Notwithstanding the provisions of Rule 32.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any rule that is inconsistent with the provisions of the Act.

32.5 No alteration, rescission or addition of any rule shall be valid unless it has been approved and registered by the Registrar.
## Supplementary Health Services

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<thead>
<tr>
<th>Service</th>
<th>E-mail Address</th>
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</tr>
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<tbody>
<tr>
<td>Pre-authorisation for specialised dentistry</td>
<td><a href="mailto:randwaterauth@shsdent.co.za">randwaterauth@shsdent.co.za</a></td>
<td>086 615 6696</td>
<td>086 111 45 46</td>
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<tr>
<td>Pre-authorisation for dental hospitalisation</td>
<td><a href="mailto:randwaterhosp@shsdent.co.za">randwaterhosp@shsdent.co.za</a></td>
<td>086 615 6697</td>
<td>086 111 45 46</td>
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<tr>
<td>Dental Claims</td>
<td><a href="mailto:randwaterclaims@shsdent.co.za">randwaterclaims@shsdent.co.za</a></td>
<td>086 517 7626</td>
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<tr>
<td>Dental Claim and pre-authorisation enquiries</td>
<td><a href="mailto:randwaterenquiry@shsdent.co.za">randwaterenquiry@shsdent.co.za</a></td>
<td>086 613 7790</td>
<td>086 111 45 46</td>
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## Sanlam Health Management

<table>
<thead>
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<th>Department</th>
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<tr>
<td>Hospital Pre-Authorisations</td>
<td><a href="mailto:rdw.preauth@sanlamhealth.co.za">rdw.preauth@sanlamhealth.co.za</a></td>
<td>011 707 8473</td>
<td>086 111 4476</td>
</tr>
<tr>
<td>Chronic Medicine Authorization</td>
<td><a href="mailto:rdw.medicine@sanlamhealth.co.za">rdw.medicine@sanlamhealth.co.za</a></td>
<td>011 707 8471</td>
<td>086 111 4476</td>
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<tr>
<td>Chronic Disease Management Programmes</td>
<td><a href="mailto:rdw.oncology@sanlamhealth.co.za">rdw.oncology@sanlamhealth.co.za</a></td>
<td>011 707 8472</td>
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<tr>
<td></td>
<td><a href="mailto:rdw.hiv@sanlamhealth.co.za">rdw.hiv@sanlamhealth.co.za</a></td>
<td>011 707 8469</td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:rdw.diabetes@sanlamhealth.co.za">rdw.diabetes@sanlamhealth.co.za</a></td>
<td>011 707 8467</td>
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## Scheme Contact Details

<table>
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<th>Authorisation</th>
</tr>
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<tbody>
<tr>
<td>Scheme Contact</td>
<td>011 682 0985</td>
<td>011 682 0671</td>
<td>086 111 4476</td>
</tr>
<tr>
<td>Address</td>
<td><a href="mailto:RWMED@randwater.co.za">RWMED@randwater.co.za</a></td>
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<tr>
<td>Web</td>
<td><a href="http://hosting.cumulusis.com/Randwater/home/login.asp">http://hosting.cumulusis.com/Randwater/home/login.asp</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postal Address</td>
<td>P O Box 1127</td>
<td></td>
<td>Johannesburg</td>
</tr>
<tr>
<td></td>
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<td></td>
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## Rand Water

<table>
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